General Assembly

Raised Bill No. 6382

January Session, 2013

LCO No. **2886**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING THE ELIGIBILITY TO PURCHASE A HEALTH BENEFIT PLAN OFFERED BY THE CONNECTICUT HEALTH INSURANCE EXCHANGE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-1080 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

For purposes of sections 38a-1080 to 38a-1090, inclusive, as amended by this act:

(1) "Board" means the board of directors of the Connecticut Health Insurance Exchange;

(2) "Commissioner" means the Insurance Commissioner;

(3) "Eligible individual" has the same meaning as provided in Section 1331 of the Affordable Care Act;

[(3)**]** (4) "Exchange" means the Connecticut Health Insurance Exchange established pursuant to section 38a-1081, as amended by this

act;

[(4)**]** (5) "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act, P.L. 111-152, as both may be amended from time to time, and regulations adopted thereunder;

[(5)**]** (6) (A) "Health benefit plan" means an insurance policy or contract offered, delivered, issued for delivery, renewed, amended or continued in the state by a health carrier to provide, deliver, pay for or reimburse any of the costs of health care services.

(B) "Health benefit plan" does not include:

(i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9), (14), (15) and (16) of section 38a-469 or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation insurance;

(v) Automobile medical payment insurance;

(vi) Credit insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, under which benefits for health care services are secondary or incidental to other insurance benefits.

(C) "Health benefit plan" does not include the following benefits if they are provided under a separate insurance policy, certificate or

contract or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof; or

(iii) Other similar, limited benefits specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time;

(iv) Other supplemental coverage, similar to coverage of the type specified in subdivisions (9) and (14) of section 38a-469, provided under a group health plan.

(D) "Health benefit plan" does not include coverage of the type specified in subdivisions (3) and (13) of section 38a-469 or other fixed indemnity insurance if (i) such coverage is provided under a separate insurance policy, certificate or contract, (ii) there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and (iii) the benefits are paid with respect to an event without regard to whether benefits were also provided under any group health plan maintained by the same plan sponsor;

[(6)**]** (7) "Health care services" has the same meaning as provided in section 38a-478;

[(7)**]** (8) "Health carrier" means an insurance company, fraternal benefit society, hospital service corporation, medical service corporation health care center or other entity subject to the insurance laws and regulations of the state or the jurisdiction of the commissioner that contracts or offers to contract to provide, deliver, pay for or reimburse any of the costs of health care services;

[(8)**]** (9) "Internal Revenue Code" means the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the

United States, as amended from time to time;

[(9)**]** (10) "Person" has the same meaning as provided in section 38a-1;

[(10)**]** (11) "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with subsection (e) of section 38a-1086;

[(11)**]** (12) "Qualified employer" has the same meaning as provided in Section 1312 of the Affordable Care Act;

[(12)**]** (13) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in Section 1311(c) of the Affordable Care Act and section 38a-1086, as amended by this act;

[(13)**]** (14) "Qualified individual" has the same meaning as provided in Section 1312 of the Affordable Care Act;

[(14)**]** (15) "Secretary" means the Secretary of the United States Department of Health and Human Services;

[(15)**]** (16) "Small employer" has the same meaning as provided in section 38a-564.

Sec. 2. Subsection (a) of section 38a-1081 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) There is hereby created as a body politic and corporate, constituting a public instrumentality and political subdivision of the state created for the performance of an essential public and governmental function, to be known as the Connecticut Health Insurance Exchange. The Connecticut Health Insurance Exchange shall not be construed to be a department, institution or agency of the state. The exchange shall serve **[**both**]** qualified individuals, including

eligible individuals, and qualified employers.

Sec. 3. Section 38a-1083 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) For purposes of sections 38a-1080 to 38a-1090, inclusive, as amended by this act, "purposes of the exchange" means the purposes of the exchange expressed in and pursuant to this section, which are hereby determined to be public purposes for which public funds may be expended. The powers enumerated in this section shall be interpreted broadly to effectuate the purposes of the exchange and shall not be construed as a limitation of powers.

(b) The goals of the exchange shall be to reduce the number of individuals without health insurance in this state and assist individuals and small employers in the procurement of health insurance by, among other services, offering easily comparable and understandable information about health insurance options.

(c) The exchange is authorized and empowered to:

(1) Have perpetual successions as a body politic and corporate and to adopt bylaws for the regulation of its affairs and the conduct of its business;

(2) Adopt an official seal and alter the same at pleasure;

(3) Maintain an office in the state at such place or places as it may designate;

(4) Employ such assistants, agents, managers and other employees as may be necessary or desirable;

(5) Acquire, lease, purchase, own, manage, hold and dispose of real and personal property, and lease, convey or deal in or enter into agreements with respect to such property on any terms necessary or incidental to the carrying out of these purposes, provided all such

acquisitions of real property for the exchange's own use with amounts appropriated by this state to the exchange or with the proceeds of bonds supported by the full faith and credit of this state shall be subject to the approval of the Secretary of the Office of Policy and Management and the provisions of section 4b-23;

(6) Receive and accept, from any source, aid or contributions, including money, property, labor and other things of value;

(7) Charge assessments or user fees to health carriers that are capable of offering a qualified health plan through the exchange or otherwise generate funding necessary to support the operations of the exchange;

(8) Procure insurance against loss in connection with its property and other assets in such amounts and from such insurers as it deems desirable;

(9) Invest any funds not needed for immediate use or disbursement in obligations issued or guaranteed by the United States of America or the state and in obligations that are legal investments for savings banks in the state;

(10) Issue bonds, bond anticipation notes and other obligations of the exchange for any of its corporate purposes, and to fund or refund the same and provide for the rights of the holders thereof, and to secure the same by pledge of revenues, notes and mortgages of others;

(11) Borrow money for the purpose of obtaining working capital;

(12) Account for and audit funds of the exchange and any recipients of funds from the exchange;

(13) Make and enter into any contract or agreement necessary or incidental to the performance of its duties and execution of its powers. The contracts entered into by the exchange shall not be subject to the approval of any other state department, office or agency, provided

copies of all contracts of the exchange shall be maintained by the exchange as public records, subject to the proprietary rights of any party to the contract;

(14) To the extent permitted under its contract with other persons, consent to any termination, modification, forgiveness or other change of any term of any contractual right, payment, royalty, contract or agreement of any kind to which the exchange is a party;

(15) Award grants to Navigators as described in subdivision (19) of section 38a-1084, as amended by this act, and in accordance with section 38a-1087, as amended by this act. Applications for grants from the exchange shall be made on a form prescribed by the board;

(16) Limit the number of plans offered, and use selective criteria in determining which plans to offer, through the exchange, provided individuals and employers have an adequate number and selection of choices;

[(17) Evaluate jointly with the SustiNet Health Care Cabinet the feasibility of implementing a basic health program option as set forth in Section 1331 of the Affordable Care Act;**]**

[(18)**]** (17) Sue and be sued, plead and be impleaded;

[(19)**]** (18) Adopt regular procedures that are not in conflict with other provisions of the general statutes, for exercising the power of the exchange; and

[(20)**]** (19) Do all acts and things necessary and convenient to carry out the purposes of the exchange, provided such acts or things shall not conflict with the provisions of the Affordable Care Act, regulations adopted thereunder or federal guidance issued pursuant to the Affordable Care Act.

Sec. 4. Section 38a-1084 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

The exchange shall:

(1) Administer the exchange for **[**both**]** qualified individuals, including eligible individuals, and qualified employers;

(2) Commission surveys of individuals, small employers and health care providers on issues related to health care and health care coverage;

(3) Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under Section 1311(c) of the Affordable Care Act, and section 38a-1086, as amended by this act, of health benefit plans as qualified health plans;

(4) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(5) Provide for enrollment periods, as provided under Section 1311(c)(6) of the Affordable Care Act;

(6) Maintain an Internet web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans including, but not limited to, the enrollee satisfaction survey information under Section 1311(c)(4) of the Affordable Care Act and any other information or tools to assist enrollees and prospective enrollees evaluate qualified health plans offered through the exchange;

(7) Publish the average costs of licensing, regulatory fees and any other payments required by the exchange and the administrative costs of the exchange, including information on monies lost to waste, fraud and abuse, on an Internet web site to educate individuals on such costs;

(8) Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the Secretary

under Section 1311(c)(3) of the Affordable Care Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under Section 1302(d)(2)(A) of the Affordable Care Act;

(9) Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under Section 2715 of the Public Health Service Act, 42 USC 300gg-15, as amended from time to time;

(10) Inform individuals, in accordance with Section 1413 of the Affordable Care Act, of eligibility requirements for the Medicaid program under Title XIX of the Social Security Act, as amended from time to time, the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act, as amended from time to time, or any applicable state or local public program, and enroll an individual in such program if the exchange determines, through screening of the application by the exchange, that such individual is eligible for any such program;

(11) Collaborate with the Department of Social Services, to the extent possible, to allow an enrollee who loses premium tax credit eligibility under Section 36B of the Internal Revenue Code and is eligible for HUSKY Plan, Part A or any other state or local public program, to remain enrolled in a qualified health plan;

(12) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under Section 36B of the Internal Revenue Code and any cost-sharing reduction under Section 1402 of the Affordable Care Act;

(13) Establish a program for small employers through which qualified employers may access coverage for their employees and that shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the exchange at the specified level of coverage;

(14) Offer enrollees and small employers the option of having the exchange collect and administer premiums, including through allocation of premiums among the various insurers and qualified health plans chosen by individual employers;

(15) Grant a certification, subject to Section 1411 of the Affordable Care Act, attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code, an individual is exempt from the individual responsibility requirement or from the penalty imposed by said Section 5000A because:

(A) There is no affordable qualified health plan available through the exchange, or the individual's employer, covering the individual; or

(B) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(16) Provide to the Secretary of the Treasury of the United States the following:

(A) A list of the individuals granted a certification under subdivision (15) of this section, including the name and taxpayer identification number of each individual;

(B) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code because:

(i) The employer did not provide minimum essential health benefits coverage; or

(ii) The employer provided the minimum essential coverage but it was determined under Section 36B(c)(2)(C) of the Internal Revenue Code to be unaffordable to the employee or not provide the required minimum actuarial value; and

(C) The name and taxpayer identification number of:

(i) Each individual who notifies the exchange under Section 1411(b)(4) of the Affordable Care Act that such individual has changed employers; and

(ii) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

(17) Provide to each employer the name of each employee, as described in subparagraph (B) of subdivision (16) of this section, of the employer who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(18) Perform duties required of, or delegated to, the exchange by the Secretary or the Secretary of the Treasury of the United States related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;

(19) Select entities qualified to serve as Navigators in accordance with Section 1311(i) of the Affordable Care Act and award grants to enable Navigators to:

(A) Conduct public education activities to raise awareness of the availability of qualified health plans;

(B) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under Section 36B of the Internal Revenue Code and cost-sharing reductions under Section 1402 of the Affordable Care Act;

(C) Facilitate enrollment in qualified health plans;

(D) Provide referrals to the Office of the Healthcare Advocate or health insurance ombudsman established under Section 2793 of the Public Health Service Act, 42 USC 300gg-93, as amended from time to time, or any other appropriate state agency or agencies, for any

enrollee with a grievance, complaint or question regarding the enrollee's health benefit plan, coverage or a determination under that plan or coverage; and

(E) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange;

(20) Review the rate of premium growth within and outside the exchange and consider such information in developing recommendations on whether to continue limiting qualified employer status to small employers;

(21) Credit the amount, in accordance with Section 10108 of the Affordable Care Act, of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled and collect the amount credited from the offering employer;

(22) Consult with stakeholders relevant to carrying out the activities required under sections 38a-1080 to 38a-1090, inclusive, as amended by this act, including, but not limited to:

(A) Individuals who are knowledgeable about the health care system, have background or experience in making informed decisions regarding health, medical and scientific matters and are enrollees in qualified health plans;

(B) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) Representatives of small employers and self-employed individuals;

(D) The Department of Social Services; and

(E) Advocates for enrolling hard-to-reach populations;

(23) Meet the following financial integrity requirements:

(A) Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the Secretary, the Governor, the Insurance Commissioner and the General Assembly a report concerning such accountings;

(B) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Affordable Care Act and allow the Secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to:

(i) Investigate the affairs of the exchange;

(ii) Examine the properties and records of the exchange; and

(iii) Require periodic reports in relation to the activities undertaken by the exchange; and

(C) Not use any funds in carrying out its activities under sections 38a-1080 to 38a-1089, inclusive, as amended by this act, that are intended for the administrative and operational expenses of the exchange, for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or state legislative and regulatory modifications;

(24) Seek to include the most comprehensive health benefit plans that offer high quality benefits at the most affordable price in the exchange; and

(25) Report at least annually to the General Assembly on the effect of adverse selection on the operations of the exchange and make legislative recommendations, if necessary, to reduce the negative impact from any such adverse selection on the sustainability of the exchange, including recommendations to ensure that regulation of insurers and health benefit plans are similar for qualified health plans

offered through the exchange and health benefit plans offered outside the exchange. The exchange shall evaluate whether adverse selection is occurring with respect to health benefit plans that are grandfathered under the Affordable Care Act, self-insured plans, plans sold through the exchange and plans sold outside the exchange.

Sec. 5. Subsection (a) of section 38a-1085 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) The exchange shall make qualified health plans available to qualified individuals, including eligible individuals, and qualified employers for coverage beginning on or before January 1, 2014.

Sec. 6. Subsection (a) of section 38a-1086 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) The exchange may certify a health benefit plan as a qualified health plan if:

(1) The plan includes, at a minimum, essential benefits as determined under the Affordable Care Act and the coverage requirements under chapter 700c, except that the plan shall not be required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as set forth in subsection (e) of this section, if:

(A) The exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

(B) The health carrier makes prominent disclosure at the time it offers the plan, in a form approved by the exchange, that such plan does not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by such plan are offered through the exchange;

(2) The premium rates and contract language have been approved by the commissioner;

(3) The plan provides at least a bronze level of coverage, as determined pursuant to subdivision (8) of section 38a-1084, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Affordable Care Act for catastrophic plans and will only be offered to individuals eligible for catastrophic coverage;

(4) The plan's cost-sharing requirements do not exceed the limits established under Section 1302(c)(1) of the Affordable Care Act, and if the plan is offered through the program for small employers, the plan's deductible does not exceed the limits established under Section 1302(c)(2) of the Affordable Care Act;

(5) The health carrier offering the plan:

(A) Is licensed and in good standing to offer health insurance coverage in the state;

(B) Agrees to offer at least (i) one qualified health plan at a silver level of coverage, as determined pursuant to subdivision (8) of section 38a-1084, and (ii) one qualified health plan at a gold level of coverage, as determined pursuant to subdivision (8) of section 38a-1084, through each component of the exchange in which the health carrier participates, where "component" refers to the program for small employers and the program for individual coverage;

(C) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchange or directly by the health carrier or through an insurance producer;

(D) Does not charge any cancellation fees or penalties as set forth in subsection (c) of section 38a-1085; and

(E) Complies with the regulations developed by the Secretary under Section 1311(d) of the Affordable Care Act and such other

requirements as the exchange may establish;

(6) The plan meets the requirements for certification pursuant to written procedures adopted under subsection (a) of section 38a-1082 and regulations promulgated by the Secretary under Section 1311(c) of the Affordable Care Act; and

(7) The exchange determines that making the plan available through the exchange is in the interest of qualified individuals, eligible individuals and qualified employers in the state.

Sec. 7. Subsection (b) of section 38a-1087 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(b) The exchange shall award Navigator grants, at the sole discretion of the board of directors, to any of the following entities to carry out Navigator functions: (1) A trade, industry or professional association; (2) a community and consumer-focused nonprofit group; (3) a chamber of commerce; (4) a labor union; (5) a small business development center; or (6) an insurance producer or broker licensed in this state. A Navigator shall not be an insurer or receive any consideration directly or indirectly from any insurer in connection with the enrollment of any qualified individual, eligible individual or employees of a qualified employer in a qualified health plan. An eligible entity shall not receive a Navigator grant unless it can demonstrate to the satisfaction of the board of directors of the exchange that it has existing relationships, or could readily establish such relationships, with small employers and its employees, individuals including uninsured and underinsured individuals, or self-employed individuals likely to be qualified to enroll in a qualified health plan.

This act shall take effect as follows and shall amend the following sections:

Section 1	*October 1, 2013*	38a-1080
Sec. 2	*October 1, 2013*	38a-1081(a)
Sec. 3	*October 1, 2013*	38a-1083
Sec. 4	*October 1, 2013*	38a-1084
Sec. 5	*October 1, 2013*	38a-1085(a)
Sec. 6	*October 1, 2013*	38a-1086(a)
Sec. 7	*October 1, 2013*	38a-1087(b)

Statement of Purpose:

To specify that eligible individuals, as defined in Section 1331 of the Affordable Care Act, may purchase health benefit plans offered by the Connecticut Health Insurance Exchange.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]